Answers Made to the Medical Examiner - Part II

in continuation of and forming a part of the application for insurance to

POLICE AND FIREMEN'S INSURANCE ASSOCIATION

101 East 116th Street • Carmel, Indiana 46032 • 800-221-7342 • www.pfia.net

Propsed Insured: _____ DOB _____

1. a. Name and address of your personal physician _____

b. Date and reason last consulted _____

c. What treatment was given or medication prescribed? _____

2. Have you been treated for or had any known indication of:	YES	NO
a. Disorder of eyes, ears, nose or throat?	❑	❑
b. Dizziness, fainting, convulsions, severe or frequent headache, speech defect, paralysis or stroke, mental or nervous disorder?	❑	❑
c. Shortness of breath, persistent hoarseness or cough, blood spitting, chronic bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	❑	❑
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	❑	❑
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorderof the stomach, intestines, liver or gallbladder?	❑	❑
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidneys, bladder, prostate or reproductive organs?	❑	❑
g. Diabetes, thyroid or other endocrine disorders?	❑	❑
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	❑	❑
i. Deformity, lameness or amputation?	❑	❑
j. Disorder of skin, breasts, lymph glands, cyst, tumor or cancer?	❑	❑
k. Allergies, anemia or other disorder of the blood?	❑	❑
l. Any immune deficiency disorder, AIDS, the AIDS related complex (ARC) or test results indicating exposure to the AIDS virus?	❑	❑
3. Have you had any care or treatment or medical advice for alcohol usage?	❑	❑
4. Have you used any of the following more than twice: Amphetamines, barbiturates, hallucinogenics, narcotics or marijuana? If prescribed for you by a physician, please explain	❑	❑
5. Have you smoked cigarettes in the past 12 months?	❑	❑
6. Are you now under observation or taking treatment? List medications, with dosage, any special diet within the last 5 years. Give dates	❑	❑
7. Have you had any change in weight in the past year?	❑	❑
8. Other than above, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	❑	❑
b. Had a checkup, consultation, illness, injury, surgery?	❑	❑
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	❑	❑
d. Had electrocardiogram, X-ray, other diagnostic test?	❑	❑
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	❑	❑
9. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	❑	❑

Details of "Yes" answers. ***(Please, Identify question number, circle applicable items:*** *Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.)*

	Age if Living	*Cause of death*	*Age at death*
Father			
Mother			
Siblings # Living _____ # Dead _____			

I declare that the statements and answers shown above are true and complete to the best of my knowledge and belief, and I agree that they shall be considered the basis of any insurance issued. **Dated at** _____ **this** _____ **day of** _____, 20____

Witness _____ M.D.

Signature of Medical Examiner

_____

Signature of Proposed Insured (or Parent/Guardian if Proposed Insured is a Minor)

Medical Examiner's Report (not part of the application) Part III

10. a. Height *(in shoes)* ____ *ft.* ____ *in.* | Weight *(clothed)* _____ *lbs.* | Chest *(full inspiration)* _____ *in.* | Chest *(forced expiration)* _____ *in.* | Abdomen, *at umbilicus* _____ *in.*

b. Did you weigh? ❑ Yes ❑ No Did you measure? ❑ Yes ❑ No

c. Is appearance unhealthy or older than stated age? ❑ Yes ❑ No

11. Blood pressure (If initial blood pressure elevated, retake later in exam.)

	1	2	3
Systolic			
Diastolic 5th Phase			

12.

Pulse:	At Rest	After Excercise	3 Minutes Later
Rate:			
Irregularities per minute			

13. Heart; is there any: Enlargement ❑ Yes ❑ No Dyspnea ❑ Yes ❑ No

Murmur(s) ❑ Yes ❑ No Edema ❑ Yes ❑ No

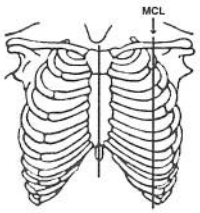
(describe below - if more than one, describe separately)

Location	Murmur(s) M no.1	M no.2
Constant	❑	❑
Inconstant	❑	❑
Transmitted	❑	❑
Localized	❑	❑
Systolic	❑	❑
Presystolic	❑	❑
Diastolic	❑	❑
Soft (Gr. 1-2)	❑	❑
Mod. (Gr. 3-4)	❑	❑
Loud (Gr. 5-6)	❑	❑

Apex by . . X

Murmur area by . . . .O

Transmission by . . . . . →



Describe all murmurs or abnormal heart sounds. Include intensity, location, area of transmission and pertinent effects of exercise and body position. We want your diagnosis!

14. Is there, on examination, any abnormality of the following:	YES	NO
a. Eyes, ears, nose, mouth, pharynx?	❑	❑
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (incl. scars), lymph nodes, varicose veins?	❑	❑
c. Nervous system (include reflexes, gait, paralysis)?	❑	❑
d. Respiratory system?	❑	❑
e. Abdomen (include scars)?	❑	❑
f. Genitourinary system (include prostate)?	❑	❑
g. Endocrine system (include thyroid and breasts)?	❑	❑
h. Musculoskeletal system (include spine, joints, amputations and/or deformities)?	❑	❑
i. Retinopathy (indicate K-W)	❑	❑
j. Peripheral pulses (decreased, bruits)?	❑	❑
15. a. Are there any hernias?	❑	❑
b. Any hemorrhoids?	❑	❑
16. Are you aware of additional medical history?	❑	❑
(A confidential report may be sent to the Medical Director)		
17. Are you alone with proposed insured and unrelated to both proposed insured and agent?	❑	❑

We rely on your clinical thoroughness to help us classify the risk from an insurance point of view. Please make sure all questions are answered and record detail of "yes" and pertinent "no" answers below.

Urine: To be voided at time of examination.

Specific gravity _____ Albumin _____ Sugar

Send to Home Office if :

- the dip stick is abnormal.
- Age of applicant is 55 or above.
- Amount applied for exceeds $100,000.
- Applicant is obese, diabetic, hypertensive, has heart disease, or has a family history of any of these.

Are you sending a specimen to theHome Office? ❑ Yes ❑ No

Check (√) ❑ Exam for Personal Insurance
❑ Exam for Group Insurance

Group Policy # _____

Name of Agent _____

I certify that I have carefully examined _____ Address _____

in private at ❑ my office, ❑ patient's business, ❑ patient's home. **Dated at** _____ **this** _____ **day of** _____, 20___

Signature of Examiner _____

Address _____

PLEASE PRINT (or use stamp)

Fee: $

SSN or Fed. ID _____

Review report carefully for completeness of all sections, then mail directly (without exception) to the Medical Director at the Home Office